

Tips and techniques for engaging and managing the reluctant, resistant or hostile young person

Louise K McCutcheon, Andrew M Chanen, Richard J Fraser, Lorelle Drew and Warrick Brewer

Assessment of most mental health problems in primary care is undertaken opportunistically.¹ Here, we discuss some of the challenges to engaging and treating young people, and suggest strategies to manage difficulties in the doctor–patient relationship.

Engagement

Normal adolescent development is characterised by significant increases in novelty-seeking, risk-taking and peer-directed social interactions, which foster the development of adult independence.² However, these changes occur more rapidly than the development of executive and regulatory skills, leading to a developmentally normal mismatch between fundamental drives and self-regulatory skills.³ This might manifest as behavioural problems, or as difficulties expressing thoughts and feelings, taking another's point of view or anticipating the consequences of one's actions.

From this perspective, most young people are usually doing the best that they can to manage and are not deliberately trying to be difficult, manipulative, or challenging to assess and treat. Adopting this non-blaming approach allows the clinician to keep an open mind about the young person's reasons for presenting, assume a cooperative stance, and avoid being controlling, authoritarian or punitive (Box 1). Young people usually want to be treated as if they are able to make decisions for themselves, but some struggle with asking for assistance, or reject help when it is offered, even when a situation feels wildly out of control.

Potential threats to engagement

Stigma

Fear and ignorance about mental illness might relate to previous clinical experiences or to anticipated rejection by clinicians or peers. Stigma can also be two-sided. Negative or demeaning attitudes of clinicians, even if unintended, are usually communicated to patients. Publicly available psychoeducational information (see <http://www.orygen.org.au>) is a useful adjunct to consultations and might assist in countering stigma and fostering engagement.

Denial and avoidance

Denial, blaming others, or blocking out negative feelings and distress through the use of drugs and alcohol are common coping mechanisms, with clear short-term adaptive benefits. Unfortunately, when used repeatedly, excessively or inflexibly, problems rarely get resolved, resulting in a vicious circle of diminished tolerance for discussion of difficulties and/or worsening problems.

When young people insist that problems belong to others alone, it is often helpful to shift the discussion to how their opinion might have become so at odds with that of others. A non-judgemental, inquisitive stance can assist patients to find a face-saving way of accepting some responsibility for the problem and agreeing to engage in treatment for their own benefit. When it is apparent that denial or avoidance is impeding treatment, this should become a focus of the treatment itself.

ABSTRACT

- Creating a collaborative doctor–patient relationship is the bedrock upon which effective treatments are delivered.
- The interaction between normal developmental changes and psychopathology can present particular challenges to clinicians attempting to assess and treat young people.
- Assuming an attitude in which young people are seen to be doing their best, rather than being deliberately difficult or manipulative, can help clinicians avoid a controlling or punitive relationship and can facilitate collaborative problem solving.
- Stigma, denial and avoidance, ambivalence, hopelessness and coercion are potential threats to engagement and must be addressed specifically.
- Challenging patients, such as the reluctant, resistant, aggressive, self-harming or intoxicated patient require specific management strategies that can be learned.

MJA 2007; 187: S64–S67

Ambivalence

Some young people are ambivalent about the idea of change, particularly when they believe the problem is their fault or they are unable to imagine life any other way. Direct discussion about their fears, and how any changes might impact upon them, their family or peers is a first step. If this is unsuccessful, motivational interviewing,⁴ or structured problem solving,⁵ incorporating examination of the costs and benefits of changing (or not changing) is often required.

Hopelessness

Hopelessness about the possibility of change can affect initial engagement and undermine treatment. Aim to invite and inspire the young person into working towards agreed and achievable goals. Psychoeducation about the potential benefits of mental health treatment can achieve this, as can searching for occasions when the patient has demonstrated some ability to overcome problems in the past. It is important to be realistic (rather than overly optimistic) about possible outcomes. Focusing on small examples can help to build a sense of achievement and success.

Coercion

Young people are commonly brought to appointments by others, such as parents, guardians or professional staff. Under these circumstances, attendance is often seen by the young person to serve the needs of others. Acknowledge this issue as real, and spend time with the patient alone finding common ground, to identify goals that meet his or her needs (Box 1). This might include a goal along the theme of “getting others to stop controlling me”.

Sometimes, despite our best efforts, a young person might refuse assessment and/or treatment. This can be distressing, especially for family members, and requires a clear explanation to all parties

1 Tips for fostering engagement with young people

- Speak to the young person directly, not just to his or her parents, or carers, or to the health care workers
- Treat the young person as responsible and capable of making (or at least having some say in) decisions
- Be honestly interested in what the young person has to say; taking a curious, non-intrusive and respectful stance can be helpful
- Clarify what the young person wants to gain from coming to see you. Try to be committed to the young person's goals, or at least find something you can agree to help the young person with, or explain clearly why you cannot help
- Balance talking about what the young person wants and what you think would be helpful
- "Be yourself"; young people seem particularly tuned in to anyone who is trying to "fake it"
- As much as possible, use language that is clear and easily understood. Jargon should be kept to a minimum and explained when it is used. Overuse of slang is probably worse than not using it at all
- Check the young person has understood what you are saying at regular intervals, without appearing condescending
- Provide psychoeducation (see <http://www.orygen.org.au>)
- Be open and honest as much as possible
- Prepare the young person for questions about potentially distressing topics (eg, before asking about sexual matters, let the young person know you are now going to ask some personal questions)
- Be flexible; tailor what you do and how you do it to the situation
- Use metaphor and humour, when appropriate, to build rapport
- Avoid being judgemental by showing empathy and tolerance, while still expressing concern for the person's safety or wellbeing
- Avoid taking a controlling, authoritarian position by explaining your concerns, if they arise, and the rationale behind your actions
- Remember, engagement is a process that may wax and wane, requiring repeated attention throughout the period of care

about the possible options, the potential consequences of acting on these options, and the limits to which they can be pursued. Clear information should also be provided about monitoring warning signs (eg, talk of death or suicide), along with when and how to act should the person change his or her mind or experience a deterioration in mental health. A safety plan can be drawn up that includes contact details and instructions for action in the event of a possible crisis. Most mental health treatment is conducted on a voluntary basis, and the various state mental health Acts stipulate specific circumstances in which compulsory treatment is allowed. This fact usually needs careful explanation to understandably worried parents or carers.

Family involvement

A young person's relationship with his or her family will vary considerably with age, living arrangements, cultural expectations, and the degree of autonomy and closeness within the family. The extent of involvement of family and important others in a patient's care should reflect individual circumstances and wishes. While involving parents is clearly important and desirable, evidence for

any benefit from mandatory parental involvement is lacking.⁶ The law recognises the rights of "mature minors" to make decisions about their medical treatment and to receive confidential health care.⁶ Treating a young person without parental involvement might become necessary when family members are opposed to the patient's wishes or are likely to undermine effective treatments (to which the young person is able to give informed consent). Moreover, mental health problems (in the young person and/or his or her parent[s]) might affect the presentation and engagement of young people or family members.

Try to establish early in the course of treatment what the young person prefers and whether there are specific reasons for not wanting family involvement, such as stigma, shame, or previous adverse clinical experiences. It is often helpful to describe the pitfalls of not involving the family, such as lack of support or the likelihood of poor medication adherence if a young person needs to conceal his or her medication. In such cases, clearly document your assessment of the young person's capacity to give informed consent. Family involvement might vary over time, and initial refusal to include family members might be revised at a later date, especially when issues of stigma or shame have been addressed.

Confidentiality

Sanci and colleagues^{1,6} have comprehensively discussed confidentiality in relation to young people, including its application to mental health problems. In practice, confidentiality needs to be discussed at the outset of any consultation. If family or carers are involved, this should be done (or reiterated) in their presence. This should also include an explanation of the limits to confidentiality, and family members or carers should be reassured that ensuring the patient's safety will always be paramount. Patients can also be reassured that only sufficient information to ensure their safety or that of others would ever be shared with specific others, rather than wholesale disclosure of all personal information.

Attendance

Young people often miss appointments or arrive late. Try to establish whether the lateness or missed appointments might be evidence of avoidance, a direct manifestation of their mental illness, or the result of immature organisational skills. While it is important to explain your own needs (fairness to other patients, payment, etc), it is crucial not to be punitive in your response to these sorts of behaviours. While a punitive approach might yield short-term satisfaction for the clinician, it is likely to make the situation worse, result in patient drop-out, and reduce the likelihood of help-seeking.

Severe mental health problems, such as disorganised behaviour, paranoid ideas or social anxiety often directly impair the patient's capacity to access services. Under these circumstances, outreach services are usually the only means of assessing and providing treatment. The under-resourcing of youth mental health services means that general practitioners are often left to deal with these problems. These situations are frustrating, but the above principles apply just as much, if not more. Aiming for structured routine and consistency, along with the above strategies, enhances the chance of engagement but does not guarantee this outcome. In the event of a poor outcome, referral to tertiary mental health services should be attempted.

2 Preventive steps to ensure safety in the event of a patient becoming hostile

- Have two people in the room with the young person; do not see the young person on your own, and explain why you are doing this
- Staff should sit closest to the exit, so that it cannot be blocked; however, the young person should also have clear access to the exit
- Attempt to discuss your concerns in a non-judgemental way with the patient; for example, "It is important that both you and I feel safe at all times, so if you start to feel angry, I am asking that you let me know so we can take a break. I might also ask for a break, if I think we need one. We can either talk again when you feel OK, or we can make another time to continue. Do you think that you can agree to do that?"
- It is important to acknowledge that everyone feels angry at different times. However, there are appropriate and inappropriate ways of dealing with angry feelings
- Avoid getting into a polarised position with the patient; inevitably, this will result in heavy-handed management strategies, or a breakdown in the therapeutic alliance, or both
- If a patient becomes oppositional, try to find another way around the situation, rather than becoming locked into a battle
- Trust your intuition — if you feel in danger, then you may well be!

by asking the patient what it is that he or she wants is frequently helpful, but often overlooked as a strategy. Once again, it is useful to let the patient know your own needs and limits, the safety of all concerned being paramount. Box 2 suggests preventive steps to take, if you believe that there is a risk of a young person becoming aggressive during an interview. Box 3 outlines basic management strategies to use if a young person becomes violent, threatening or intimidating during an interview.

Actual or threatened deliberate self-harm

Deliberate self-harm (DSH; for example, self-cutting, deliberate overdose of licit or illicit substances), which is common among young people in Australia,⁷ is strongly associated with mental health problems⁸ and, when associated with the intent to die, it is the single most potent risk factor for completed youth suicide.⁹ It should therefore be taken seriously and a thorough risk assessment should always be performed.

Apart from the intent to die, DSH might also serve functions such as the regulation of negative affect, communication of distress, expression of emotions, or coping with dissociative states.¹⁰ The reasons for a particular incident are not always clear to the observer or even to the young person.

Young people who engage in DSH, especially repeated DSH, are often described as "attention-seeking" or "manipulative". In fact, they are usually very ineffective manipulators, and it is the coarseness and transparency of their actions that makes them so poor at getting what they want and need. It is more helpful to consider that the young person uses such self-destructive coping strategies because they have not yet learned more appropriate and effective ones. Adopting this approach allows the clinician to empathise with the young person's distress and to avoid feeling victimised or exploited by the patient, which only increases the likelihood of provoking a dismissive or even punitive reaction.

If DSH is assessed to be a coping strategy, treatment should assist the young person to assess the costs and benefits of this strategy and to try new ones that might be more effective or cause less harm. It is important to understand that repeated DSH is usually experienced by the young person as successful in some way. This often seems counterintuitive to clinicians, but patients can usually tell you that "it works", at least in the short-term. It is unrewarding

The challenging patient

Reluctance or resistant behaviour

One of the most frustrating presentations is the young person who will not speak. Unless he or she was coerced, attending your appointment usually indicates some degree of cooperation. Reluctance to speak might arise from the presenting problem (eg, auditory hallucinations commanding the patient to remain silent), fear of being judged, concerns about not being taken seriously or the patient's genuine inability to express him or herself. In the latter case, some gentle encouragement and perhaps tentative guesswork (checking with the patient as much as possible) might be sufficient. Sometimes, it is helpful to begin by asking about interests, achievements or strengths, and then move on to more difficult topics. When a young person is unable or unwilling to provide information, other sources of information should be used. Try to gain the patient's cooperation or collaboration, and explain your reasons for seeking information from others, what you will say to them, and reiterate your commitment to confidentiality.

Conducting a risk assessment under these circumstances is very difficult. If you find yourself having to guess or make assumptions, explain these to the young person and seek his or her opinion. Explain that, to ensure the patient's safety and prepare appropriate supports, you need to explore the worst case scenario. As a clinician in such a situation, you might have little choice but to act unilaterally.

Hostile, angry or threatening behaviour

Anger is a normal human emotion and is not always indicative of mental illness. It is often a healthy reaction to perceived threat or loss of control. Failure to acknowledge a patient's affect is a key pitfall in this situation. Check to see why the patient is angry and whether you might be contributing to this. Defusing the situation

3 Managing aggressive behaviour

- Protect yourself and others from any harm; this might result in evacuating other people from a waiting area or leaving a door open
- Speak calmly and avoid raising your voice
- Attempt to listen for what the young person really wants of you; this might be different from what is actually being said. Clarify your interpretation with the young person
- Try to communicate clearly what you can and can't do
- Try to communicate clearly what you want the young person to do; for example, "I can't think clearly when you speak so loud. Please can you speak in a normal voice? Then I can try to tell you what I can do to help."
- Communicate clearly what your limits are and the consequences of the patient's behaviour; for example, "It is not acceptable to damage my property. Please leave now or we will have to call the police."

for clinicians to argue against this or respond in a punitive way. Patients should feel able to disclose their behaviour without feeling judged. Cost–benefit analysis or motivational interviewing⁴ can sometimes help to model tolerance, while exploring reasons (eg, distraction or regulation of affect) for behaviour such as DSH without condoning its use and the consequences of such strategies.

Although DSH might initially also prompt care from others, if repeated it can soon begin to elicit frustration or rejection from others and shame in the self-harmer. Sometimes, the realisation of this can prove a potent motivator for change in the patient. It is sensible to be clear about your concern for the young person's wellbeing, and that your aim is to help the young person work towards reducing this behaviour and developing more appropriate and effective coping strategies. Provision of psychoeducation, especially about risks (eg, wound infection, potential lethality of paracetamol), is important but should not instruct patients how to harm themselves more effectively.

In general, the chronic self-harmer is unlikely to change his or her behaviour quickly. In attempting to consider how much chronic risk is acceptable, it is important to understand how the usual level of risk might have changed. Any new life event, a recent onset of a mental health problem (eg, depression), or a sudden elevation of risk or potential lethality should be taken seriously and followed by an appropriate clinical response.

Chaotic or disorganised behaviour

This difficult presentation often necessitates gathering information from other sources if you are unable to obtain it from the young person. Try to ascertain if the problems are longstanding or of recent onset. The former might reflect immaturity, cognitive deficits, or behavioural problems. The latter might reflect intoxication or a recent-onset mental disorder, such as psychosis. If the young person is presenting to you for the first time and is not currently receiving specialised mental health treatment, referral to a mental health service might be appropriate.

Intoxication

Intoxication presents difficulties in patient participation and the patient's ability to give informed consent to treatment. A risk assessment is usually indicated. However, obtaining a history of the types and amounts of substances consumed is often difficult. For high-risk situations, such as aggressive or acutely suicidal behaviour, the principles we have outlined above still apply. For

lower-risk situations, or for routine appointments when the patient is known to you, it is usually prudent to reschedule the appointment, as it is highly unlikely that the young person will recall what is said during the appointment. Therefore, any important information or instructions for the patient should be written down.

Competing interests

None identified.

Author details

Louise K McCutcheon, DPsych, MAPS, HYPE Clinic Coordinator,¹ Research Fellow²

Andrew M Chanen, MB BS, MPM, FRANZCP, Associate Medical Director,¹ Senior Lecturer²

Richard J Fraser, MSc, MRCPsych(UK), Psychiatrist¹

Lorelle Drew, MB BS, FRANZCP, Psychiatrist¹

Warrick Brewer, MA(ClinNeuropsychology), PhD, Associate Professor²

¹ ORYGEN Youth Health, Melbourne, VIC.

² ORYGEN Research Centre, University of Melbourne, Melbourne, VIC.

Correspondence: achanen@unimelb.edu.au

References

- 1 Sanci L, Vance A, Haller D, et al. Common mental health problems in adolescence. In: Blashki G, Judd F, Piterman L, editors. *General practice psychiatry*. Sydney: McGraw-Hill, 2006.
- 2 Spear LP. The adolescent brain and age-related behavioral manifestations. *Neurosci Biobehav Rev* 2000; 24: 417-463.
- 3 Steinberg L. Cognitive and affective development in adolescence. *Trends Cogn Sci* 2005; 9: 69-74.
- 4 Arkowitz H, Westra HA, Miller WR, Rollnick S, editors. *Motivational interviewing in the treatment of psychological problems*. New York: Guilford Press, 2007.
- 5 Treatment Protocol Project. *Management of mental disorders*. 4th ed. Sydney: World Health Organization Collaborating Centre for Mental Health and Substance Abuse, 2004.
- 6 Sanci LA, Sawyer SM, Kang MS, et al. Confidential health care for adolescents: reconciling clinical evidence with family values. *Med J Aust* 2005; 183: 410-414.
- 7 De Leo D, Heller TS. Who are the kids who self-harm? An Australian self-report school survey. *Med J Aust* 2004; 181: 140-144.
- 8 Welch SS. A review of the literature on the epidemiology of parasuicide in the general population. *Psychiatr Serv* 2001; 52: 368-375.
- 9 Bridge JA, Goldstein TR, Brent DA. Adolescent suicide and suicidal behavior. *J Child Psychol Psychiatry* 2006; 47: 372-394.
- 10 Paris J. Understanding self-mutilation in borderline personality disorder. *Harv Rev Psychiatry* 2005; 13: 179-185.

(Received 8 Mar 2007, accepted 25 Jun 2007)

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